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A NEW OPERATION FOR THE REDUCTION OF CHRONIC INVERSION OF THE UTERUS.*

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After devoting a considerable amount of time to the study of the different methods of replacing a complete inversion of the uterus of long standing, and appreciating the difficulties and dangers attending the operations already devised, I concluded to adopt a new procedure in a case which resisted many of the methods referred to.

The simplicity of the operation, and the ease and success with which it was performed, lead me to suggest it as one to be considered in all difficult cases.

The problem to be solved is, how to get the fundus back through the rigid and constricted cervix.

The injuries which frequently result from prolonged taxis, such as rupture of the vagina, rupture of the uterus, peritonitis, etc., are well known. Repeated failures at reduction have occurred to the most skilful operators. Up to this time Thomas's method, which consists in abdominal section over the cervical ring and dilatation from above, has been the only one that could be said to be absolutely sure of accomplishing the replacement in cases which had resisted the other plans—such as the rapid reduction by taxis; Noeggerath's method of indenting one horn of the uterus and reinverting it first; Courty's method of passing two fingers into the rectum and dipping them into the cer-

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vical ring, with counter-pressure upon the fundus; Emmet's plan of receiving the fundus in the palm of the hand and spreading the fingers out in the vagina, with counter-pressure from above; or the very excellent and successful method of Dr. I. H. Tate, of Cincinnati, which consists in holding the cervical end of the uterus firmly between two fingers in the rectum and one in the bladder, while the thumbs press upon the fundal extremity.

The patient upon whom I operated presented the following history:

Mrs. I., aged twenty-eight, white, married ten years, has had two children, the youngest six years of age, and has had no miscarriage since. She is a large, stout woman, with thick abdominal walls, weighs about two hundred pounds, and has all the appearance of perfect health. Three months after her last confinement she had a severe hemorrhage from the vagina upon rising in the morning. She lay at the point of death for nine weeks, and since then has been unable to be out of bed for more than two or three weeks at a time, suffering at intervals with hemorrhages, which have lasted from two to four weeks. She has had to be extremely careful in her movements at all times, for fear of bringing on a hemorrhage. Her attending physician had made the diagnosis of "bleeding tumor of the uterus," and offered from time to time to remove it, which, fortunately, was not done.

In March, 1883, she came under my care, and was examined under an anæsthetic. The diagnosis of chronic inversion of the uterus was made. A prolonged effort at reduction by taxis did not succeed in restoring the uterus, but a profuse hemorrhage was excited by the manipulations, and the vagina had to be tamponed with cotton saturated with dilute Monsel's solution. A short time afterward another ineffectual effort at reduction was made. Then continued pressure with Gariel's air-pessary was resorted to, and used for six weeks, followed at the end of that time by another ineffectual effort at reduction by taxis. In October she came into the Woman's and Child's Hospital, where I made another attempt at reduction, trying Noeggerath's and Courty's methods, but again with failure. The os could be plainly felt through the rectum, but the cervix was so firm and unyielding that it could not be made to dilate.

On November 2d, the bowels and bladder having been evacuated, she was placed under ether, the inverted fundus was drawn outside the vulva with a strong vulsella forceps, the openings of both Fallopian tubes were brought plainly to view, and an incision one inch and a half in length was made through the posterior portion of the uterus (avoiding the Fallopian tubes and larger vessels at the sides of the uterus). Through this incision Sims' large dilator was passed up into the cervix and expanded to the fullest extent; the rigid tissues of the cervix were felt to relax; then, upon withdrawing this dilator, Nos. 2 and 3 of Hank's hard rubber dilators (three-fourths and one inch in diameter) were passed through the cervix. The finger was also passed to feel that there were no adhesions. The incision in the uterus was then sewed up with carbolized silk-worm gut, and, with slight manipulation, the fundus was easily replaced through the now passable constriction.

The whole operation was performed in less than thirty minutes. There was considerable hemorrhage from the uterine cavity when the uterus was first replaced. On the next day the temperature was 102° Fahr., but gradually returned to the normal condition, which it reached on the fourth day. During the first week she complained of severe pain in the uterus, but this was controlled by full doses of opium.

She was placed upon the table and examined on the 14th (twelve days after the operation). The cervix was somewhat patulous, but, with this exception, the parts were all in a normal condition.

Conclusions.

1. This operation is not proposed to supersede ordinary taxis in the reduction of chronic inversion of the uterus.

2. It is not more dangerous, but much more certain, than prolonged or rapid taxis.

3. We avoid the danger of bruising the tissues and rupturing the vagina.

4. As an operation for inversion, it is less dangerous than laparotomy.

5. Unless there be adhesions (which rarely exist), we can always feel certain of reducing the inversion at one operation.